

## Zero-Dose Learning Week pre-event webinar (part 2) Q&A: emerging evidence on reaching ZD children

Question	Presenter Response	Presenter
<p>Are there plans to compile the gender integrative strategies/best practices from the submitted abstracts?</p>	<p>Further synthesis will be performed for the ZD learning Week events across critical areas and that should include gender. Materials will be shared to all attendees.</p>	<p>Dr. Gustavo Corrêa</p>
<p>Did any of these strategies target hard core zero dose i.e., not catch up first zero dose catch up efforts? Were there special factors of these hard core?</p>	<p>Majority of the abstracts focused on the some of the following aspects:</p> <ul style="list-style-type: none"> <li>a) outreach to reduce the number of zero-dose children</li> <li>b) increase the immunization coverage of eligible children</li> <li>c) carry out Periodic Intensification of Routine Immunization (PIRI)</li> <li>d) test the effectiveness of strengthened PHC linkage</li> <li>e) improve accessibility and utilization of vaccination services.</li> </ul> <p>Among other abstracts that were examples such as</p> <ul style="list-style-type: none"> <li>a) A study from Uganda that aimed to assess and enhance vaccination access in refugee settlements by reinstating routine immunization services</li> <li>b) A study from Pakistan which investigated the prevalence of zero-dose pentavalent and another one to identify and locate ZDC by using the Electronic Immunization Registry (ZM-EIR)</li> </ul> <p>However, it is not always clear if the strategy was a hard core ZD in a new population such as a newly established refugee camp/ a new urban slum or an unreached population.</p>	<p>Dr. Sunitha Chandrasekhar</p>
<p>Is there a strategy to scale some of these promising interventions / programs (civil society, community engagement, mixed methods, etc.) presented?</p>	<p>Authors of abstracts have highlighted the key linkages between their approaches and the need to scale-up these interventions which are critical for sustainability. They have provided recommendations on how their findings can be used to scale up partnership with CSO, integrating immunization with other health and non-health services, using M&amp;E, stake holder collaboration for community-centric approaches, using geo-spatial analysis, leveraging the strengths of a well-funded polio campaign and existing digital platforms to support ZD reach activities, institutionalization of Mobile Immunization Teams, Negotiating access timeframes with Non State Arms Groups, etc.</p>	<p>Dr. Sunitha Chandrasekhar</p>

<p>How many studies reported cost per child as a policy informing data point?</p>	<p>Among 41 REACH abstracts, three abstracts provided insight on the cost as follows.</p> <ul style="list-style-type: none"> <li>a) JSI conducted a narrative review of current studies on estimating the costs of increasing childhood vaccination and reducing the prevalence of ZD children in LMICs. They highlighted those costs of interventions varied by type of intervention and ranged from \$0.08 per additional dose for a cellular phone contact to encourage return visits in Kenya, to \$67 per dose for a cash transfer intervention in Nicaragua. They also highlighted how most articles did not provide descriptions of their costing methods.</li> <li>b) A study from India reporting on Periodic Intensification of Routine Immunization (PIRI), evaluated the impact on doses delivered and ZDC reached. They also estimated the incremental costs of IMI per dose delivered and per ZDC reached. In the 40 districts with cost data, the incremental cost per dose delivered was \$6.21, and the incremental cost per ZDC reached was \$82.99.</li> <li>c) National Centre of Immunization (CNI) in Mali reported on how they plan to conduct a cost-effectiveness analysis to generate evidence for future scale-up of the urban strategy for reaching the unreached in urban and peri-urban areas, focusing on the impactful role of the “Women-Leaders”.</li> </ul>	<p>Dr. Sunitha Chandrasekhar</p>
<p>Curious to know if there were any approaches to quantify the average cost of identifying or reaching a ZD child?</p>	<p>The ZD Costing group has done some work on that and will bring guidance in the ZD learning week may event on the 11<sup>th</sup> of September.</p>	<p>Dr. Gustavo Corrêa</p>
<p>How did we determine which ones we consider ‘promising’ and which ones aren’t? i.e. to what extent do we have evidence already on whether these interventions were successful at reaching ZD kids and which ones weren’t.</p>	<p>Based on the information provided by the authors that ones where they were successful on reaching ZD children were collated as promising interventions.</p>	<p>Dr. Sunitha Chandrasekhar</p>
<p>Are you planning to scale in Somalia e.g. to Jubaland? As the IDP situation fluctuates?</p>	<p>Yes, we have expansion plans in Juba land although they are subject to funds availability. The expansion is need-based and CGPP focus in hard-to-reach cross border areas, partially accessible and inaccessible areas all in Juba land state.</p>	<p>Josephine Ihahi</p>

<p>And are you able to provide integrated services? Could you please give an example?</p>	<p>In Somalia, the TPVs provide only immunization and screening for vaccine preventable diseases. However, the project is wide and in partially accessible and inaccessible areas, the health camp model provides integrated health services i.e. Maternal health consultations (Antenatal/postnatal care), nutrition screening, general medical consultation and, referrals for critical conditions requiring specialized care.</p> <p>However, in Kenya, we incorporate health, animal and environment activities in a One Health approach, providing One Stop services for hard-to-reach populations i.e., Human (Vaccination, general consultation and treatment, nutrition screening, maternal health, Lab services, civil registration) Animal (animal treatment, vaccinations) and Environment (Tree planting, Environmental conservation activities).</p>	<p>Josephine Ihahi</p>
<p>Did the project team collect any data on associated costs/cost effectiveness of the CGM model?</p>	<p>The ZD project is in pilot phase in Dadaab refugee camp, which is a complementary project for TPV. This aim to understand the reasons why children are zero-dose from the point of origin.</p> <p>Yes, we are collecting data not directly on cost effectiveness but the number of neighborhood mothers with ZDC back in Somalia, and how many of those have been vaccinated as a result of peer sensitization by care group mothers in the camp.</p> <p>Motivational incentive provided are basically visibility materials (Jackets, tote-bags, notebooks, scarfs, pens and mobile airtime vouchers to enable them call neighborhood/peer mothers back in their villages in Somalia)</p>	<p>Josephine Ihahi</p>
<p>Do you think CGM is a cost-effective approach to reach ZD?</p>	<p>Yes, CGM is a very effective approach. The incentive provided are basically irregular in-kind (Jackets, tote-bags, notebooks, scarfs, pens and mobile airtime vouchers to enable them call neighborhood in Somalia). Comparing this with health awareness creation awareness among caregivers in inaccessible areas and the number of ZDC identified, referred and immunized is definitely an cost effective approach.</p>	<p>Josephine Ihahi</p>
<p>For the Transit Point Vaccination intervention, what was the rate of acceptance/refusal by caregivers of children identified to be ZD at the transit points?</p>	<p>So far, no vaccination refusal has been recorded by TPVs from caregivers traversing Somalia-Kenya-Ethiopia border.</p>	<p>Josephine Ihahi</p>

<p>I'm just curious to know about the kind of motivational incentives given to caregivers/mothers? and how often are they provided (at every contact with the health facility or is it just a one-time incentive provided)? How is it perceived by the government?</p>	<p>The incentive provided are basically irregular in-kind (Jackets, tote-bags, notebooks, scarfs, pens and mobile airtime vouchers to enable them call neighborhood in Somalia). The government has no issue since its in-kind incentives mostly visibility material for identification, while supporting us tracking of new arrival in the camps.</p>	<p>Josephine Ihahi</p>
<p>When you say "86% of ZD children in new resettlements were reached", what do you mean? Do you mean that you vaccinated children 12-23m who were found to be ZD? The definition of children who are ZD is children 12-23m who have not received DTP1 ... so you technically when you are vaccinating a ZDC, you are doing catch-up, not reducing the number of ZD.</p>	<p>Zimbabwe has adopted the definition of ZD children as those children who lack the first dose of diphtheria-tetanus-pertussis containing vaccine (DTP1). Likewise, the result meant that of the 5,122 Zero Dose Children identified through Community Mapping in new resettlements, 86% were reached and vaccinated with DTP1 at first contact.</p>	<p>Meggie Gabida</p>
<p>When you say "86% of ZD children in new resettlements were reached", what do you mean? Do you mean that you vaccinated children 12-23m who were found to be ZD? The definition of children who are ZD is children 12-23m who have not received DTP1 ... so you technically when you are vaccinating a ZDC, you are doing catch-up, not reducing the number of ZD.</p>	<p>I meant We vaccinated children 0-59 months who had not been vaccinated before with any routine antigen including DPT1, essentially, these are ZDC.</p>	<p>Josephine Ihahi</p>
<p>Why did the data become more than 100%?</p>	<p>I am assuming this is related to the graph on DTP 3 coverage. The inherent population denominators have left some children unaccounted for making the efforts of immunization to reach populations not catered as part of the total population in the catchment area. Important to note is that this was unique to urban districts and districts with highly mobile populations. The observation was beyond the scope of our work and, we proposed a recommendation to conduct further in-depth analysis on data quality, accuracy of population data and triangulation.</p>	<p>Meggie Gabida</p>

<p>What was the approach used to reach children with disabilities (or parents with disabilities)?</p>	<p>Just to step back, the initial community ZD mapping that we did at Inception, was integrated with a childhood NCD disease burden mapping, and identifying children with functional difficulties was part of the data that was collected at household level. Likewise, we ensured the same strategies used were disability inclusive.</p> <ol style="list-style-type: none"> <li>1. Every month the VHWs were tasked to visit all households within their catchment area recording the services required by the community including households with members with a disability in preparation for the facility based, district based integrated outreach or mobile clinic. VHWs were given adequate messaging on package of services that will be provided including for people with disabilities thereby empowering caregivers to seek services.</li> <li>2. The Multi-Disciplinary Team included a Physiotherapist or Rehabilitation Technician to provide specialist support to children and adults with a functional difficulty.</li> <li>3. The Service Delivery Points were set up as close as possible to people's everyday environment increasing access to services to all community members.</li> <li>4. In three of the districts, we used Community Development Trust partnerships to better serve people with disabilities. The Trust provided transportation to carry the people with disabilities to the Service Delivery Points.</li> </ol>	<p>Meggie Gabida</p>
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